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M E M O R A N D U M

DATE: February 10, 2004

TO: Metropolitan King County Councilmembers

FROM: Cheryle A. Broom, County Auditor

SUBJECT: Special Study of King County Health Benefits

The council requested this study as part of the auditor's 2003 Annual Work Program. The study examined King County health care costs, how these costs are changing, and what opportunities the county has for containing cost growth.

The study focused on four central questions: (1) How do increases in King County's health care costs compare to national and local trends? (2) What are the components of King County's health care costs and to what extent are they driving costs? (3) How does King County's benefits package compare with those of other employers? and (4) Do proven best practices exist for effectively and efficiently controlling health care costs, and if so, is King County employing them? We addressed these questions by reviewing data from a range of health benefit surveys and studies, and by conducting our own survey of large government employers in the Puget Sound region. We also reviewed industry best practices to identify viable health cost containment strategies.

The study found that King County's health benefit costs have increased faster than national averages, but these increases have been in line with those experienced by other Puget Sound governments. Hospital services and the cost of prescription drugs are the primary drivers behind rising health care costs for King County. King County's health benefits coverage is more generous than national averages but is in line with coverage offered by other Puget Sound governments. Best practices do exist for containing health cost growth, and King County has taken several steps to implement them. Best practices include introducing consumerism in health plans, contracting for pharmaceutical benefit management, and introducing disease management programs. King County implementation in these areas helped to reduce cost growth in 2003.

The study also recommends that Human Resources Division continue to pursue the implementation of best practices, especially where such practices have been proven to control health cost growth. The executive concurred with this recommendation. The executive's Health Care Advisory Task Force is reviewing options for further implementation of best practices. We appreciate the cooperation of management and staff within the Department of Executive Services.

SPECIAL STUDY

KING COUNTY HEALTH BENEFITS

Presented to
the Metropolitan King County Council
Labor, Operations & Technology Committee
by the
County Auditor's Office

Cheryle A. Broom, King County Auditor
Elizabeth DuBois, Senior Management Auditor
Rob McGowan, Senior Management Auditor
David Reynolds, Management Auditor

Report No. 2003-04
February 10, 2004

Auditor's Office Mission

We conduct audits and other studies to identify ways to improve accountability, performance, and efficiency of county government.

Auditor's Office Vision

We are committed to producing substantive work of the highest quality and integrity that results in significant improvements in accountability, performance, and efficiency of county government. We share a commitment to our mission, to our profession, and to a collaborative work environment in which we challenge ourselves to accomplish significant improvements in the performance of the King County Auditor's Office.

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The King County Auditor's Office was created in 1970 by the King County Home Rule Charter as an independent agency within the legislative branch of county government. Under the provisions of the charter, the County Auditor is appointed by the Metropolitan King County Council. The King County Code contains the policies and administrative rules for the Auditor's Office.

The King County Auditor's Office provides oversight of county government through independent audits and other studies regarding the performance and efficiency of agencies and programs, compliance with mandates, and integrity of financial management systems. The office reports the results of each audit or study to the Metropolitan King County Council.

The King County Auditor's Office performs its work in accordance with applicable Government Auditing Standards, with the exception of a pending external quality control review.

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Audit and study reports are available on our website (www.metrokc.gov/auditor) in two formats: entire reports in PDF format (1999 to present) and report summaries (1992 to present). Copies of reports can also be requested by mail at 516 Third Avenue, Rm. W-1020, Seattle, WA 98104, or by phone at 206-296-1655.

Alternative Formats Available Upon Request

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Abbreviations

CDHP	Consumer-Driven Health Plan
DUR	Drug Utilization Review
HMO	Health Maintenance Organization
HRD	Human Resources Division
PBM	Pharmaceutical Benefits Manager
PPO	Preferred Provider Organization
ROI	Return on Investment
TPA	Third Party Administration

EXECUTIVE SUMMARY

Introduction

In 2003, roughly 12,000 King County employees were receiving health benefits through the county's three standard health benefit plans. The county expected to spend about $91.3 million on health benefits for these employees over the year. Because health benefit costs represent a significant portion of the county's annual payroll expenditures, and because these costs are growing faster than other payroll-related expenses (average annual growth since 2000 has been 17 percent per employee), the council directed the auditor to review the health benefits program and evaluate the county's experience relative to other comparable employers.

General Conclusions

In general, our study concluded that:

- King County's health benefit costs have increased faster than national averages, but these increases have been in line with those experienced by other Puget Sound governments.
- King County's health benefits coverage and cost-sharing approach are more generous than national averages but are in line with other Puget Sound governments.
- King County has taken several steps to control costs that are consistent with industry best practices. These include introducing consumerism in county health plans and contracting for both pharmaceutical benefit management and cardiovascular disease management. These changes helped King County reduce growth in health benefit costs for 2003.

Scope and Objectives

Our study examined King County health care costs in light of national and regional trends and compared the county's health care benefits package with those of comparable employers. Our study also reviewed best practices and opportunities for controlling health care costs in the future. Our study did not consider health benefit costs within a "total compensation" framework. Total compensation review typically considers all remuneration received by an employee, including salaries and wages, benefits and insurance, vacation and sick leave, and allowances for training, transportation, and uniforms.

Summary of Findings and Recommendations

Finding 1: For the period 2000 to 2003, King County's health benefit rates increased faster than averages experienced by similar employers nationwide. However, the county's rate of increase was comparable to that experienced by other large public employers in the Puget Sound region.

In 2001 and 2002, King County's per-employee health benefit costs rose at a faster rate than all national averages we reviewed for comparable employers, though in 2003, King County dropped below these same averages. This shift coincides with the start of a new three-year health plan in 2003, reflecting changes in benefit design which appear to be holding costs down. By contrast, King County's increase in per-employee health benefit costs was similar to that experienced by other large public sector employers in the region, and not significantly different from the regional average.

Finding 2: The primary drivers behind rising health care costs for King County are the cost of hospital services and the cost of prescription drugs.

For 2000-2002, health care utilization statistics showed that hospital services and prescription drugs were the primary factors driving increases in King County's health care costs. Hospital services alone were responsible for 52 percent of the total cost increase from 2000 to 2002. Though a third major cost component, physician services, continues to represent a significant share of total costs, this cost center is growing more slowly than KingCare health costs overall.

Finding 3: King County's health benefits coverage and cost-sharing approach are more generous than those offered by large Seattle employers and employers nationally but are similar to those of other large Puget Sound governments.

King County's health coverage is more generous than coverage offered by large Seattle employers and employers nationally, though the surveys we reviewed included responses from private as well as public employers. King County's health benefits coverage is similar to coverage offered by other area government employers. Although King County does not require premium sharing, this practice is the most common arrangement for public employers in the region.

Finding 4: King County has taken several steps to control costs that are consistent with industry best practices. These include introducing consumerism in county health plans and contracting for both pharmaceutical benefit management and cardiovascular disease management.

The county has introduced consumerism in its health plans by implementing a three-tiered pharmaceutical benefit, which is estimated to save the county almost $6 million between 2003 and 2005, or approximately 15 percent of all prescription drug claims. Starting in 2003, the county also contracted for pharmaceutical benefit management and cardiovascular disease

management, which is expected to help control the increases in the cost of prescription drugs and the treatment of one chronic condition. Human Resources Division (HRD) could improve its implementation of best practices by educating employees to be better health care consumers and expanding the county's disease management program.

Recommendation: The study recommends that HRD continue to pursue best practices that have been shown to control health benefit costs. Some of the most promising areas include educating employees to be better health care consumers and expanding the county's disease management program.

Acknowledgement

The Auditor's Office wishes to thank HRD staff for their cooperation and collaboration on this project.

1 INTRODUCTION

This study examined King County health care costs in light of national and local trends and compared the county's costs, benefits coverage, and employer-employee cost-sharing approach with those of comparable employers. It also reviewed industry best practices and opportunities for controlling health care costs in the future.

Health Care Costs Represent a Significant and Growing Portion of King County's Overall Benefits Package

In 2003, roughly 12,000 King County employees were receiving health benefits through the county's three standard health benefit plans. The county expected to spend about $91.3 million on health benefits for these employees over the year. Because health care costs represent a significant and growing portion of the county's overall benefits package (up to 78 percent of total benefit cost in 2002 from 73 percent in 2000), and because these costs are growing faster than other payroll-related expenses (average annual growth since 2000 has been 17 percent per employee), the council directed the auditor to review this program and to evaluate the county's experience relative to other comparable employers.

Study Scope and Objectives

Auditor's Office Compared County Health Costs to Those of Other Employers

The scope of this study included the county's Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) health benefit plans for active, full-time, regular employees. These plans drive the majority of the county's health benefit costs and provide health coverage for 93 percent of the county's full-time regular employees. The study excluded the relatively smaller costs of dental, vision, life insurance, and long-term disability plans, as well as health plans for retirees, part-time workers, and deputy sheriffs. The study also did not review

health benefit costs within a "total compensation" framework. Total compensation review typically considers all remuneration received by an employee, including salaries and wages, benefits and insurance, vacation and sick leave, and allowances for training, transportation, uniforms, and so forth.

Within the scope of our review, the study addressed the following five questions:

- How do increases in King County's health care costs compare to national and local trends?
- What are the components of King County's health care costs and to what extent are they driving costs?
- How does King County's benefits package and employer-employee cost-sharing approach compare with those of other employers?
- Do proven best practices or policies exist in terms of effectively and efficiently controlling health care costs? If so, is King County employing them? If not, what are the potential savings if they were pursued?
- Based on the above, what policy options for employee benefits are available?

Methodology

Auditor's Office Reviewed National Data and Surveyed Large Public Employers in the Region

In addressing the central questions of the study, the auditor's office reviewed data from a range of health benefits surveys and studies. We also conducted our own survey of large government employers in the Puget Sound region and gathered information similar to that found in the larger surveys. The sources of data used are described below.

National Survey – Kaiser Family Foundation

National studies on employer health benefits are conducted by the Kaiser Family Foundation each year and provide information on health care cost trends and benefit plan characteristics. Data

typically is compiled by firm size, region of the country, and industrial sector.

Regional Survey – Mercer Human Resources Consulting

Like the Kaiser Family Foundation, Mercer conducts an annual survey of employer-sponsored health plans nationwide. For our study, Mercer drew from its 2002 survey and produced a "profile report" that provides information on health benefits from a statistically valid sample of large Seattle employers, or those with 500 or more employees.

Puget Sound Public Sector Employers – Auditor's Office Survey

With assistance from the Benefits and Well-Being Section of the county's Human Resources Division (HRD), the auditor's office developed and conducted its own survey of large public employers in the Puget Sound region. Motion 10262, adopted by the King County Council in 1997, establishes a regional "market" for purposes of comparison "to determine the appropriate compensation" for King County employees. This market includes Pierce and Snohomish counties; the cities of Seattle, Tacoma, Everett, and Bellevue; the Port of Seattle; the University of Washington; and the state of Washington. The King County Auditor's Office surveyed these same jurisdictions to learn about health care cost trends and current health benefit plans within this designated market.[1]

Background on County Health Care Plans

The county offers three standard health plans: two Preferred Provider Organizations (PPOs) – KingCare Basic and KingCare Preferred – and one Health Maintenance Organization (HMO) – Group Health. Roughly 79 percent of eligible employees have

[1] The city of Tacoma and the University of Washington did not submit a response to the survey, while the Port of Seattle submitted only a partial response.

enrolled in the two KingCare programs, 20 percent are enrolled in the Group Health program, and 1 percent have opted out.

The KingCare plans are self-insured; that is, the county covers the cost of medical claims from plan members. King County contracts with a Third Party Administrator (TPA), Aetna, to negotiate discounts with hospitals and providers and to process the claims for the KingCare plans. King County also contracts with AdvancePCS to process its pharmaceutical claims and to provide other services as a Pharmaceutical Benefits Manager (PBM).

The Group Health plan is fully-insured; that is, the county pays a flat premium rate per employee to Group Health, and Group Health processes and pays medical claims for the members of its HMO.

County Has Just Completed First Year of Three-Year Health Benefit Plan

Revised health benefit plans typically are negotiated every three years as part of the county's "coalition bargaining" process, and a new three-year cycle began in 2003. Most county employees, regardless of union membership status, are receiving this new benefits package. However, the approximately 640 sheriff's deputies are an exception, as their union does not participate in coalition bargaining. This union negotiates a separate health benefits package, an arrangement which is typical for law enforcement agencies across the state.

2 COMPARING KING COUNTY'S COSTS, TRENDS, AND COVERAGE WITH OTHER EMPLOYERS

Chapter 2 provides answers to three of our five study questions:

- How do increases in King County's health care costs compare to national and local trends?
- What are the components of King County's health care costs and to what extent they are driving costs?
- How do King County's health benefits package and employer-employee cost-sharing approach compare with those of other employers?

In general, we found that:

- King County's health care costs were increasing faster than national averages but were in line with increases experienced by other Puget Sound governments.
- The cost of hospital services and prescription drugs were the county's primary health cost drivers.
- King County's health coverage and cost-sharing approach were more generous than national averages but in line with those of other governments in our region.

HOW DO INCREASES IN KING COUNTY'S HEALTH CARE COSTS COMPARE TO NATIONAL AND LOCAL TRENDS?

To compare King County health benefit cost increases with national and local trends, the auditor's office reviewed numerous national surveys and also conducted its own survey of comparable Puget Sound jurisdictions. This section describes the results of this effort.

Cost Trends – King County Compared to National and Regional Averages

King County's Health Benefit Costs Rose Faster Than National Averages in 2001 and 2002 but Fell Below Them in 2003

Using Kaiser's annual employer health benefits surveys, the auditor's office compared King County's increase in per-employee health benefit costs with average rates of increase experienced by similar employers. Comparison categories included all firms, jumbo firms (firms with more than 5,000 employees), employers in the west, and state and local governments. King County's costs rose faster in 2001 and 2002 than the averages for each of these categories, though the rate of increase dropped below these averages in 2003. This shift coincides with the start of a new three-year health plan in 2003, and reflects changes in benefit design initiated by HRD which appear to be holding costs down. These changes are discussed in Chapter 3.

Exhibit A below provides trend data for each of the Kaiser averages and for King County. Percentage figures indicate change from the previous year.

EXHIBIT A

Health Care Expenditures Per Employee – National Rates of Increase

	2001 Trend	2002 Trend	2003 Trend	Avg. Annual Increase
All firms	11.0%	12.7%	13.9%	12.5%
Jumbo firms (5000+)	10.8%	13.0%	13.2%	12.3%
Western Region	10.9%	12.7%	16.3%	13.3%
State/Local Gov.	14.6%	13.9%	12.8%	13.8%
King County	**18.2%**	**15.5%**	**9.7%**	**14.5%**

SOURCE: Kaiser Family Foundation Annual Employer Health Benefits Surveys, and King County Human Resources Division.

Cost Trends – King County Compared to Other Puget Sound Public Employers

King County's Health Benefit Costs Rose at Rates Comparable to Other Public Employers in the Region

Using responses to our own survey, we compared King County's increase in per-employee health benefit costs to those experienced by other large public sector employers in the region. The results show that the county's rate of increase was not significantly different from the regional average in any year, or for the three-year period.

Exhibit B below provides trend data for each of the surveyed jurisdictions. Percentage figures indicate change from the previous year. It should be noted that variability experienced from year to year by individual jurisdictions is much greater than variability experienced by the national averages summarized above. Often, an abrupt change in rate of health cost increase corresponds to the beginning of a new health benefit cycle for the jurisdiction.

EXHIBIT B

Health Care Expenditures Per Employee – Puget Sound Government Rates of Increase

	2001 Trend	2002 Trend	2003 Trend	Avg. Annual Increase
Bellevue	24.2%	11.8%	2.2%	12.7%
Everett	10.1%	27.9%	13.7%	17.2%
Seattle	36.4%	0.7%	1.1%	12.7%
Pierce County	23.3%	12.4%	No Data	No Data
Snohomish County	7.0%	13.3%	-3.2%	5.7%
State of WA	11.9%	7.6%	18.9%	12.8%
King County	**18.2%**	**15.5%**	**9.7%**	**14.5%**
Mean	**18.7%**	**12.8%**	**7.1%**	**12.8%**

SOURCE: King County Auditor's Office survey.

Finding 1: For the period 2000 to 2003, King County's health benefit rates increased faster than national averages. However, the county's rate of increase was comparable to that experienced by other large public employers in the Puget Sound region.

WHAT ARE THE COMPONENTS OF KING COUNTY'S HEALTH CARE COSTS AND TO WHAT EXTENT ARE THESE COMPONENTS DRIVING COSTS?

The auditor's office reviewed national data to determine how factors driving growth in health costs have been measured by the major research groups. We also reviewed King County health benefit utilization statistics provided by Mercer Human Resources Consulting, the county's primary health services consultant, to determine county cost composition and drivers.

Cost Drivers – Nationwide

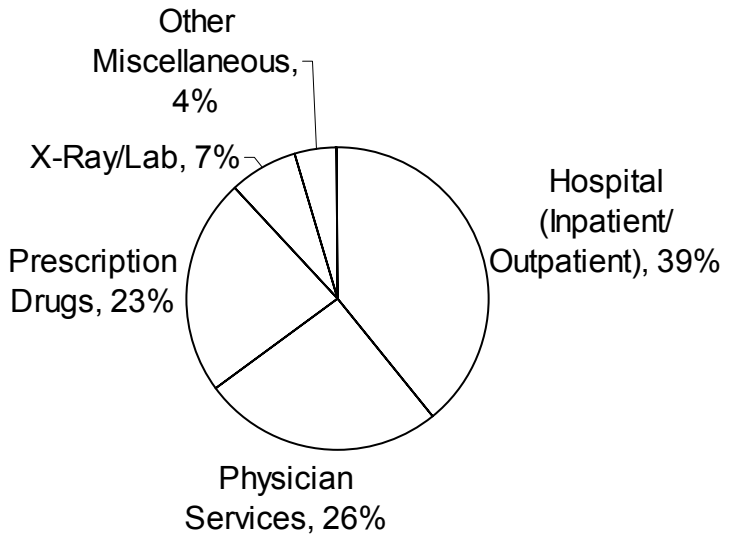
The national surveys provide limited information on factors driving the increase in health care costs. Some of the factors which the surveys did list – e.g., an aging population, medical advances, direct advertising by pharmaceutical companies – are difficult to quantify. However, the Kaiser Family Foundation regularly asks its survey participants to list those factors which they feel are contributing "a lot" to cost increases. Since 2000, respondents have listed prescription drugs, hospital services, and physician services in that order as the primary factors driving their increasing costs.

Cost Components – King County

Hospital Services, Physician Services, and Prescription Drugs Are Primary Components of County Health Costs

In 2002, health care utilization statistics for King County's two self-insured plans – KingCare Basic and KingCare Preferred – showed that the three factors identified as primary cost drivers by Kaiser respondents were also the largest components of total program costs in King County. Hospital costs, including both inpatient and outpatient services, were the largest component of the KingCare programs, representing 39 percent of total costs. Physician services were the second largest component, representing 26 percent of total costs. Prescription drugs were the third largest component, representing 23 percent of total costs. Exhibit C below illustrates this distribution.

EXHIBIT C
Components of 2002 King County Health Benefit Costs



SOURCE: King County Benefit Plan Overview, 2001 and 2002 Plan Years. Mercer Human Resources Consulting. July 2003.

Cost Drivers – King County

Hospital Services and Prescription Drugs Have Been Primary Drivers Behind Increased Costs

For 2000-2002, health care utilization statistics showed that of the three major cost components in the KingCare programs, hospital services and prescription drugs were the primary factors driving increased costs. Hospital services alone were responsible for 52 percent of the total cost increase from 2000 to 2002, and prescription drugs 31 percent. Though the third major cost component, physician services, continues to represent a significant share of total costs, this cost center is growing more slowly than KingCare health costs overall. The following exhibit shows the recent average rate of increase for the various KingCare health care services and identifies their relative importance as drivers of health benefit cost growth.

EXHIBIT D
Health Services as Percentage of Total Health Benefit Costs – KingCare

	2000-2002 Average Annual Increase	2000-2002 % of Total Increase
Hospital (Inpatient/Outpatient)	27%	52%
Physician Services	12%	18%
Prescription Drugs	27%	31%
X-Ray/Lab	-1%	-2%
Other	6%	1%
Total	**18%**	**100%**

SOURCE: Mercer Human Resources Consulting

Local Conditions Have Raised Hospital Services Costs in King County

It is interesting to note that hospital services ranks higher than prescription drugs as a cost driver for King County, while Kaiser survey respondents placed this cost center below prescription drugs in importance. This may be due to local conditions in the hospital market which have caused hospital services costs to increase more rapidly in our region. In 2003, the Center for Tracking Health System Change cited the merger of Providence Health System and Swedish Medical Center as a significant cost driver for health care in the region. Two of the region's three major hospital systems – the University of Washington and Virginia Mason – have "closed staffs," meaning that doctors providing services in these hospitals are part of hospital staff. This leaves Swedish as the primary admitting hospital for community and independent physicians, giving that system considerable leverage in determining going rates for hospital services. Other sources also acknowledged the importance of this cost driver; however, no source we reviewed quantified its effect on overall health care costs.

Additional Factors

King County's Rate of Unionization, Rate of Dependent Coverage, and Average Employee Age Also Increase Costs

Using data from its 2000 national survey, Mercer Consulting documented the impact of three factors which contribute to higher than average health benefit costs per employee. These were (1) a rate of unionization at or above 50 percent, (2) a rate of employees electing dependent coverage at or above 65 percent, and (3) an average employee age of 45 or higher. All three factors are impacting King County health benefit costs. The county's rate of unionization is 86 percent; 71 percent of employees elect dependent coverage; and average employee age is 47. In 2000, Mercer estimated that these factors alone would push health care costs in King County 29 percent above the average, though other compensating factors – the county's size and the fact that health costs are generally lower in the western U.S. – helped to mitigate at least some of these effects.

Finding 2: The primary drivers behind rising health care costs for King County are the cost of hospital services and the cost of prescription drugs.

HOW DOES KING COUNTY'S HEALTH BENEFITS PACKAGE COMPARE WITH THOSE OF OTHER EMPLOYERS?

In 1999, under contract to the auditor's office, Garner Consulting compared King County's employee benefits package to those of several other Washington government employers. The methodology Garner used to evaluate King County's health benefits was an "actuarial analysis," which assigned point values to each of the health plans at each of the surveyed employers, based on guidance provided by the American Academy of Actuaries. This allowed Garner to compare "the employer-provided value of the county's health benefits for most employees" with those of other comparable jurisdictions.

An actuarial valuation of health plans was beyond the scope of this study. However, we examined some of the same health plan characteristics that Garner used in its 1999 study as a rough determination of the county's current coverage and the extent to which health care costs are shared by the employer and employee. Specifically, we looked at the following health plan characteristics:

- **Individual Deductibles.** Deductibles are flat dollar amounts for medical services that must be paid by the plan member before insurance pays all or a percentage of the remaining price of the service. The lower the deductible, the less financial responsibility there is for the plan member, and therefore the greater the value of the coverage. Health plans often have two levels of deductibles – one for the individual covered, and a separate higher deductible for covered family members. Deductibles are common for PPO plans, but are rare for HMO plans.
- **Doctor's Office Copays.** Copays are fixed dollar amounts that a plan member pays at the point of service for medical care. The higher the copay, the greater the cost of service borne by the plan participant, and therefore the lower the value of the coverage. Health plans often have two levels of copays – one for doctor's office visits, and a separate higher copay for emergency room visits.
- **Individual Out-of-Pocket Maximums.** Out-of-pocket maximums represent the greatest financial risk to which a plan member will be exposed in a calendar year. The lower the out-of-pocket maximum, the less financial risk there is for the plan member, and therefore the greater the value of the coverage. Health plans often have two out-of-pocket maximums – one for the individual covered,

and a separate higher out-of-pocket maximum for the covered family.

- **Premium Sharing for Individual Coverage.** The premium is the monthly amount contributed per employee to cover the cost of health care. Premium sharing reflects the extent to which responsibility for these contributions is split between employer and employee. Often (but not always for self-insured employers), the employer calculates a separate premium for individuals and for families.

Cost-sharing – King County Compared to National and Regional Averages

King County's Health Coverage Is More Generous Than That of Employers Nationally and Large Seattle Employers

Using health survey data from both Mercer and Kaiser, we compared King County's cost-sharing approach with national and Seattle-area averages. King County's health coverage is more generous than coverage offered by employers nationally and by large Seattle employers, though the Kaiser and Mercer surveys included responses from private as well as public employers. For example, King County requires no premium sharing or office copay for its PPO, while employers nationally and large Seattle employers average a $15 copay and 15 and 14 percent premium sharing respectively.

King County's Health Coverage Is Similar to That Offered by Other Public Employers in the Region

Cost-sharing – King County Compared to Other Puget Sound Government Employers

Using responses to our own survey, we compared King County's cost-sharing approach with those of other government employers in the region. King County's health coverage is similar to that offered by other public sector employers, but differs in three respects: its PPO out-of-pocket maximum is 36 percent less than the median, its HMO copay is twice as high as the median, and it requires no premium sharing. Although the average premium sharing arrangement for area public employers is 5 percent for PPOs and 4 percent for HMOs, King County's practice of requiring no premium sharing is the most common arrangement– half of our survey respondents required no premium sharing for either type of plan.

Exhibits E and F below show how King County's cost-sharing approach compares to national, Seattle area public and private, and Puget Sound public sector employers.

EXHIBIT E
PPO Coverage

	King County	Area Public Employers	Seattle Employers	Employers Nationally
Median Deductible	***$100***	***$100***	No data	$275
Median Copay	***$0***	***$0***	$15	$15
Median Out of Pocket Maximum	***$800***	***$1,250***	No data	No data
Average Premium Sharing	***0%***	***5%***	14%	15%

SOURCES: King County Auditor's Office survey, Mercer Human Resources Consulting Profile Report, Kaiser Family Foundation Annual Employer Health Benefits Survey.

EXHIBIT F
HMO Coverage

	King County	Area Public Employers	Seattle Employers	Employers Nationally
Median Copay	***$20***	***$10***	$11	$15
Median Out of Pocket Maximum	***$1,000***	***$1,000***	No data	No data
Average Premium Sharing	***0%***	***4%***	15%	15%

SOURCES: King County Auditor's Office survey, Mercer Human Resources Consulting Profile Report, Kaiser Family Foundation Annual Employer Health Benefits Survey.

Finding 3: King County's health benefits coverage and cost-sharing approach are more generous than those offered by large Seattle employers and employers nationally, but are similar to those of other large Puget Sound government employers.

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3 BEST PRACTICES IN CONTROLLING HEALTH CARE COSTS

Chapter 3 provides answers to our fourth study question:

- Do proven best practices or policies exist in terms of effectively and efficiently controlling health care costs? If so, is King County employing them? If not, what are the potential savings if they were pursued?

Some best practices for controlling health care costs can be recommended, though most authorities emphasize that no cure-all exists. In three areas that offer promise – encouraging consumerism among plan members, managing prescription drug benefits, and managing chronic diseases – King County has made some advances. As noted, the rate of increase in county health care costs dipped in 2003. This coincided with the implementation of several cost saving best practices. These best practices and King County's implementation of them is further described below.

DO PROVEN BEST PRACTICES OR POLICIES EXIST FOR EFFECTIVELY AND EFFICIENTLY CONTROLLING HEALTH CARE COSTS? IF SO, IS KING COUNTY EMPLOYING THEM? IF NOT, WHAT ARE THE POTENTIAL SAVINGS IF THEY WERE PURSUED?

Although the literature provides no cure-all for escalating health care expenses, several strategies are available to help control costs. The following best practices provide an opportunity to control health care costs for King County:

- Encouraging consumerism among plan members
- Managing prescription drug benefits
- Managing chronic diseases

King County has begun to implement several best practices that have been shown to control medical costs. The following sections describe these best practices, review local and national trends in implementing them, and explain to what extent King County has included them in its health benefits program.

Encouraging Consumerism

Consumerism Encourages Health Plan Members to Make Cost-Effective Choices

While it shields users from the financial risk of illness and injury, medical insurance also insulates those covered from the actual cost of medical treatment. When someone else is paying the bill, the health care consumer has little financial incentive to seek the most cost-effective treatment. Most strategies for increasing consumerism call for giving employees more of a financial stake in their medical treatment decisions. These strategies are believed to reduce costs for the insurance plan because they encourage plan members to make more cost-effective choices in their medical care. The following sections discuss different approaches to instilling health plan members with consumer values.

Education

Education Should Convey Importance of Being Informed Health Care Consumers

Educating employees is a central strategy for encouraging consumerism because "design changes alone will not result in a consumer-focused culture."[2] Targeted newsletters, intranet postings, or other employee relations media should explain to members:

[2] "Health Care Consumerism: Buzz Phrase or Effective Strategy." *Aon Consulting Forum*. October 2003.

- Why health care costs are rising.
- How rising costs affect them and the employer's ability to continue providing the same level of coverage.
- Why it is important to become informed, educated consumers of health care services.
- How they will benefit from being informed, responsible health care consumers.

Another approach to making plan members more aware of the costs of their services is ensuring that these costs are not hidden from view. For example, some employers require pharmacies to report the full drug price on receipts along with the price members pay.

Tiered Pharmacy Benefit Designs

Tiered Pharmacy Benefit Designs Provide Incentives for Choosing Less Expensive Drugs

Perhaps because pharmaceutical costs have increased so dramatically in recent years, pharmacy benefit design is one of the first and most robust examples of designing benefits to promote consumerism. The simplest drug plans require a single copay for any prescribed drug. However, that system provides no incentive to choose generic drugs that are as effective as more expensive brand name drugs. Tiered pharmacy benefit systems address this issue.

In a two-tiered pharmacy benefit plan, a member pays a smaller copay for generic drugs than for brand name drugs. A variant of the two-tiered plan is "mandatory generic," where a member pays a single copay for generic drugs, and pays both the copay and the difference between the cost of a brand-name drug and a generic when the member chooses a drug other than generic.

A three-tiered system requires its lowest copays for generic drugs, a mid-range copay for "preferred" drugs, and the most expensive copay for "non-preferred" drugs. "Preferred" drugs

refer either to brand name drugs without generic substitutes or to drugs listed on the "formulary." (Pharmacy benefit managers develop a formulary, which is a list of drugs that are standard treatments and have been proven to be effective.) "Non-preferred" drugs are either brand name drugs with generic equivalents or drugs not in the formulary.

Employers may use coinsurance (a percentage of the cost of the drug) in lieu of a flat fee. Some plans mix copays and coinsurance, e.g., a flat fee for generic drugs and a percentage of cost for brand name drugs.

RAND, a Washington, D.C. research institute, conducted a study of the financial impact of moving from flat copays for prescription drugs to multi-tier plans. In their study, such a change could save a plan 19 percent of its annual prescription drug expenses.

Consumer-Driven Health Plans

CDHPs Combine Cash Accounts With High Deductibles to Encourage Responsible Spending

Consumer-Driven Health Plans (CDHPs) are considered a more revolutionary approach to encouraging consumerism. They combine cash accounts with high deductibles to encourage responsible spending among plan members. The most basic features of CDHPs are:

- A predefined, employer-financed account ($1,000 or $1,500, for example) that a covered employee may use for health-related expenses.
- A high deductible insurance plan combined with insurance for catastrophic events. (High deductible insurance is less expensive for the employer and insurer, yet covers expenses if chronic illness or accidents occur).
- Easy access to health information, including information on wellness and health from websites and periodic newsletters.

Savings from CDHPs are supposed to arise as employees become more responsible for their health care decisions; visit the emergency room, hospital, and doctor's office less often; use generic drugs more often; and substitute less expensive health consultation options, such as nurses help lines, for more expensive direct health care visits.

CDHPs May Disproportionately Benefit the Young and Could Upset Health Plan Risk Pools

One widely acknowledged drawback of consumer-driven health care is that it may benefit the young and healthy at the expense of the older and infirm. When consumer-driven health plans are presented as an option along with traditional plans, those in good health are likely to choose plans with higher deductibles and lower premiums, those with chronic conditions are likely to stick with traditional plans to reduce their financial risk. When this division happens, the risk pool is upset, and the traditional plans end up costing more.

Local and National Trends Toward Consumerism

Snohomish County Has Used Education to Promote Health Cost Awareness

Anecdotally, local employers expressed interest in educating their employees about the cost of health care. For example, Snohomish County prints the employer-provided portion of health insurance premiums on every pay stub to educate employees about the full cost of their benefits. Although Snohomish County has not measured the results, county finance managers believe the practice has helped employees understand the high and rising cost of health care and has increased employee willingness to accept cost containment strategies.

Three-Tiered Prescription Drug Plans Are Most Prevalent Design Locally and Nationally

The three-tiered prescription drug benefit is the most common pharmaceutical benefit design among large Seattle businesses, with 45 percent employing such a system. The second most popular design is a two-tiered system, used by 36 percent of large Seattle employers. Five of the eight area government jurisdictions in our survey reported using a three-tiered prescription drug benefit design, while two reported using a two-tiered benefit design. Only one area government uses a flat prescription drug copay, regardless of drug type.

At the national level, three-tiered systems have become the most prevalent design. Use of three-tiered systems by employers has increased from 27 percent nationally in 2000 to 63 percent in 2003, according to Kaiser.

No Large Seattle or Local Public Employer Has a CDHP

No large Seattle employer or surveyed local government reported having a CDHP, though 27 percent of large Seattle employers reported they were somewhat or very likely to offer one in the next two years. While the reluctance to adopt a consumer-driven plan may reflect employers' skepticism of their benefits, evidence suggests that employers are concerned by the difficulty of implementing such plans. According to Kaiser's 2003 survey, "consumer-driven health care approaches are unproven and require employers to substantially increase the out-of-pocket costs for some of their employees, a move that may be even less popular than managed care."[3]

King County and Consumerism

King County Has a Three-Tiered Drug Plan

King County has introduced consumerism in its pharmacy benefit by using a three-tiered copay system. Its three tiers ($10/$20/$30) are similar to both the average copays nationwide

[3] Kaiser Family Foundation. Employer Health Benefits 2003 Annual Survey, p. 8. "Managed care" refers to a heath insurance system where someone other than the doctor or patient has the power to make or influence decisions about resource consumption. Both Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are managed care systems.

($9/$19/$29) and the average copays among large Seattle employers ($11/$19/$34). Exhibit G shows the estimated savings associated with this change over the 2003-2005 contract period.

EXHIBIT G
Estimated Savings from Implementing a Tiered Rx Benefit

2003	2004	2005	Total
$ 1,900,000	$ 1,980,000	$ 2,080,000	**$ 5,960,000**

SOURCE: HRD.

These savings were estimated by the county's actuary. Based on 2002's $12,917,489 total prescription costs, the annual prescription drug savings are approximately 15 percent, slightly more modest than the estimates from RAND's study.

CDHPs Would Be Unlikely to Stem the Increase in King County's Health Costs

Consumer-driven health plans would not have a significant impact on the growth in the county's health care costs. This is because the majority of King County's costs are generated by only 10 percent of plan members whose costs far exceed the deductibles that would be paid by consumers under CDHPs.

Managing Prescription Drug Benefits

Prescription Benefit Management Promotes Improved Drug Usage While Controlling Costs

In order to decrease health plan spending on pharmaceuticals, both the public and private sectors have begun to manage their prescription drug coverage more aggressively. Traditionally, pharmacy benefits were managed by the primary health insurer. However, as the industry has become more specialized and technology requirements have increased, employers have begun to "carve out" pharmacy benefits and manage them separately through pharmacy benefit managers. This often results in a more successful program.

Prescription drug management has two sometimes compatible and sometimes divergent objectives: (1) to improve drug usage, and (2) to control drug costs. Achieving each objective requires implementation of a specific set of strategies.

Improving Pharmaceutical Usage

One strategy to improve drug usage is the implementation of Drug Utilization Review (DUR). Under DUR, a pharmacy benefits manager reviews the plan's processed pharmaceutical claims in order to:

- Reduce negative drug interactions.
- Reduce duplicative prescriptions (two or more medications unnecessarily being taken for the same ailment).
- Identify candidates for disease management programs (discussed below).
- Research and promote positive drug treatment outcomes for plan members.

Pharmacy benefit managers often have the unique technological resources needed to scan prescription files and implement DUR.

Controlling Costs

While improved drug utilization itself can reduce overall plan costs (e.g., fewer negative drug interactions means better results with fewer complications), there are several strategies that are designed specifically to reduce or control pharmaceutical costs. These include:

- **Encouraging consumerism in the pharmacy benefit program.** Pharmacy benefit managers encourage consumerism by introducing differentials, or tiered plans, in the cost of drugs. This approach is explained in detail in the previous section. Some cities and counties have used their benefit newsletters to explain how direct-to-consumer advertising for expensive prescription drugs affects the health benefit costs for members.
- **Negotiating discounts from drug manufacturers, pharmacies, and distributors.** Pharmacy benefit managers may negotiate prices for prescription drugs from every level in the supply chain. For example, an organization might tighten its network by limiting pharmacies that covered employees can use. This in turn could enable benefit managers to negotiate steeper discounts for drugs purchased under the plan.
- **Organizing purchasing coalitions with other agencies and/or jurisdictions.** Purchasing coalitions are groups of different organizations, jurisdictions, or agencies within jurisdictions that join together to maximize purchasing power and drive down drug prices. Maine has established a program that leverages Medicaid dollars to offer cheaper drugs for non-Medicaid eligible residents of the state. This plan, called “Maine Rx,” requires that drug companies provide their federally negotiated Medicaid discounts to the entire state population, regardless of benefit coverage. If companies refuse to offer these discounts, their drugs require prior authorization from Medicaid program administrators before doctors can prescribe them. While Maine Rx has successfully weathered a drug industry challenge in the US Supreme Court, some aspects of the program still face legal challenge.

King County and Pharmacy Benefit Management

Several Forces Driving Increased Drug Costs Are Beyond County's Control

As noted in Chapter 2, prescription drug benefits are one of the two primary drivers behind cost increases in King County, and special attention has been devoted to understanding and controlling these costs. Several forces appear to be driving the increased costs both nationally and for King County, and for the most part these drivers are beyond the county's control. The most frequently cited include:

- An increase in the number of prescriptions being issued.
- The escalating cost of drugs being offered.
- Direct-to-consumer advertising from pharmaceutical companies which creates demand for specific drugs.
- Consolidation in the pharmaceutical industry that limits competition and drives up costs.

King County Began Managing Its Prescription Benefit Separately in 2003

Industry challenges notwithstanding, King County carved out pharmacy benefit management for the first time in 2003. In the past, the county's third party administrator had subcontracted with vendors to process pharmaceutical benefit claims. The county's contract with its pharmaceutical benefit manager, AdvancePCS, includes DUR and disease management, which is discussed in more detail in the following section.

Managing Diseases

A majority of health care dollars in most plans is spent on a small population that suffers from chronic conditions. On average, 69 percent of health care spending nationally is consumed by 10 percent of health plan members.

Disease Management Promotes Cost-Effective Options for Treating Chronic Conditions

Disease management addresses the issue of the disproportionately high cost of chronic diseases. Although implementation of disease management can take many different forms, it usually centers upon intervention when health plan members are predisposed to or already afflicted by certain

diseases. This intervention – through check-up calls from nurses, suggested courses of treatment proven to be effective, education about healthier lifestyles, or other means – attempts to steer health plan members toward more effective (and less costly) management of their condition. Often, a disease management program offers rewards to those who agree to participate. These rewards may include free consultations and literature about their disease, reduced (or waived) copays for treatment, or reduced premium payments.

Not all diseases are candidates for disease management, and several criteria may be used to determine whether a disease management program is appropriate for a particular health plan. These include the following:

- The health plan has a large population with a chronic condition for which a treatment plan exists that is superior to all other approaches.
- A process exists to refer the subjects to the disease management program.
- The details of the treatment plan are acceptable to both the area physicians and the patients.
- Ongoing communication exists among the provider, patient, and program.
- Resource consumption data is available to compare the costs with other similar programs.

In order to identify which chronic conditions within a plan population might make good candidates for disease management, claims utilization data generally is reviewed. Some of the most common chronic conditions where disease management is implemented include:

- Diabetes
- Congestive heart failure
- Hypertension
- Asthma
- Renal disease

Although anecdotal accounts of disease management's positive return on investment (ROI) are encouraging, there is little published evidence that disease management yields a positive ROI. The hope is that "with disease management (mid-level providers) replacing crisis management (direct physician care), physicians will have more time and a more efficient health care delivery system will result from less critical care and fewer hospital stays."[4]

The key to effective disease management contracting lies in clearly defining the goal of the program. Will it target short-term cost savings, better treatment quality, or long-term improvement in health plan participants' outcomes? Goal setting should be accomplished internally rather than being deferred to a vendor. If goals are set by the vendor, they are more likely to serve the vendor's interests, which may or may not coincide with those of the employer. For example, a health insurer that develops a disease management program may look for a return on its investment within the year, or at most within the insurer's contract period. These short-term savings may not be beneficial for an employer or its covered employees over the long term.

Pharmaceutical Benefits Managers (PBMs) may use disease management programs that have been developed by pharmaceutical companies. While this usually saves the PBM costs in developing its own program, and may ensure that medication is taken as intended, it may allow pharmaceutical

[4] "Responsible Chronic Disease Management." Health Care Purchaser. December 2001.

companies to steer participants toward their own drug therapy treatments. Purchasers of disease management services must understand what the disease management vendor's goals and incentives are, and whether they align or conflict with the purchaser's.

Local Trends in Disease Management

The state of Washington and Snohomish County reported that they have disease management programs. No other local public employer reported having such a program.

Washington Has Implemented a Disease Management Program for Diabetes

Washington State's self-insurance program, the Uniform Medical Plan, manages diabetes using two different approaches. The first approach consists of sending educational materials and invitations to enroll in an expanded case management program to members with diabetes. In addition, this approach (part of the Washington State Diabetes Breakthrough Collaborative) encourages plan members with diabetes to participate in new diabetic care guidelines. The second approach includes evaluating the use of two-way pagers for patient adherence to medications and self-care practices, as well as the use of in-home lab testing kits.

Snohomish County Implemented Disease Management in October 2003

Snohomish County just began a disease management program in October 2003. The program is administered by the county's third party administrator, and consists of reviewing claims data to identify members with specific illnesses or conditions. (Snohomish County could not provide specifics regarding diseases managed through the program.) Nurses contact members directly, and the members are provided with information and guidance for the treatment of their illnesses. The county plans to develop measurements for this program's effectiveness that will include numbers of participants and estimated savings to the county.

King County and Disease Management

Medical care to treat chronically ill employees is very costly to the county, and relatively few medical claims consume a disproportionate amount of health care resources. For example, in 2002, 10 percent of plan participants consumed 68 percent of King County's health care dollars, and 17 percent of King County's total health care dollars were spent on just 36 claims.. As mentioned earlier, this is typical of health plans nationwide.

King County Implemented a Management Program for Cardiovascular Disease in 2003

King County began implementing disease management as part of its 2003-2005 contract with AdvancePCS, the county's pharmacy benefit manager. This program aims to reduce the risk of heart attack and death from cardiovascular disease for King County employees and their families. The goals of the program are to improve plan member knowledge, support patient self-management and risk reduction, and encourage the appropriate use of medication. The program is appropriate for King County's covered employees, since among claims of $50,000 or more, cardiovascular disease was the most expensive diagnosis in 2002 (13 claimants; $2,292,487 paid), and the second most expensive diagnosis in 2001 (16 claimants; $1,592,818 paid). (Cancer was second in 2002 and first in 2001.)

AdvancePCS analyzes prescription drug claims and identifies plan members with heart-related chronic conditions. AdvancePCS then mails these members information on heart disease, smoking cessation, blood pressure monitoring, cholesterol management, healthy eating, safe exercise, and proper management of medication. These members also are invited to enroll in the disease management program, which gives them access to nationally recognized clinical guidelines and other important information. The program's success will be measured by the percentage of patients using LDL-lowering

medications, the percentage of patients using beta blockers after a myocardial infarction, and patients' lipid profiles.

Finding 4: King County has taken several steps to control costs that are consistent with industry best practices. These include introducing consumerism in county health plans and contracting for both pharmaceutical benefit management and cardiovascular disease management. Opportunities exist for HRD to strengthen the impact of these programs by expanding its consumerism efforts, broadening its disease management effort to include other diseases, and becoming actively involved in setting county-driven goals for the disease management program.

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4 CONCLUSIONS AND RECOMMENDATIONS

The Auditor's Office found that King County's benefit costs increased faster than national averages but were in line with increases experienced by other Puget Sound governments. Similarly, King County's health coverage and cost-sharing approach were more generous than national averages but were in line with those of other Puget Sound governments.

The emphasis of our research was the identification of health benefit cost drivers and of industry best practices shown to control these drivers. We identified several industry best practices that have been shown to help control medical costs, and King County has begun implementing them. The county has introduced consumerism in its health plans by implementing a three-tiered pharmaceutical benefit, which is estimated to save the county almost $6 million between 2003 and 2005, or approximately 15 percent of all prescription drug claims. Starting in 2003, the county also contracted for pharmaceutical benefit management and cardiovascular disease management, which is expected help control the increases in the cost of prescription drugs and the treatment of one chronic condition.

Recommendation: We recommend that HRD continue to pursue best practices that have been shown to control health benefit costs. Some of the most promising areas where HRD could improve its implementation of best practices include:

- **Educating employees to be better health care consumers.** King County employees need to be aware of the high cost of providing health benefits. Printing the health premium paid by the county on paycheck stubs

and ensuring that pharmacies print the full cost of prescription drugs on receipts are two examples of ways to improve employees' knowledge. HRD also should consider targeted communications explaining how employees can become better health care consumers and how this benefits both the county and its employees.

- **Expanding the county's disease management program**. While cardiovascular disease is a good first target, county utilization data shows several other chronic conditions that could be targets for disease management. HRD should consider expanding the disease management program to target other diseases and establishing appropriate goals for the program.

APPENDICES

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LIST OF FINDINGS AND RECOMMENDATION

Finding 1: For the period 2000 to 2003, King County's health benefit rates increased faster than averages experienced by similar employers nationwide. However, the county's rate of increase was comparable to that experienced by other large public employers in the Puget Sound region.

Finding 2: The primary drivers behind rising health care costs for King County are the cost of hospital services and the cost of prescription drugs.

Finding 3: King County's health benefits coverage and cost-sharing approach are more generous than those offered by large Seattle employers and employers nationally, but are similar to those of other large Puget Sound governments.

Finding 4: King County has taken several steps to control costs that are consistent with industry best practices. These include introducing consumerism in county health plans and contracting for both pharmaceutical benefit management and cardiovascular disease management.

Recommendation: The Human Resources Division (HRD) should continue to pursue best practices that have been shown to control health benefit costs. Areas where HRD could improve its implementation of best practices include educating employees to be better health care consumers and expanding the county's disease management program.

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EXECUTIVE RESPONSE

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January 8, 2004

TO: Cheryle A. Broom, County Auditor

FROM: Ron Sims, King County Executive

RE: Proposed Final Report – Special Study of King County Health Benefits

Thank you for the opportunity to review your proposed Final Report on King County Health Benefits. I concur with your findings and recommendations. I have one minor comment on Exhibit E – while you are absolutely correct that the KingCare plans do not include a copay for services, like most Preferred Provider Organization (PPO) arrangements there is *coinsurance* on claims before the maximum out of pocket expense is reached. In the KingCare Preferred plan the member pays 10 percent of all costs for services from network providers, and 20 percent of all costs from out-of-network providers. In the KingCare Basic plan the amounts are 20 percent and 30 percent respectively. Coinsurance is most typical for PPO plans, although some PPO plans use a copay arrangement instead. The surveys you cited will have information on coinsurance amounts. Most PPO plans have *either* coinsurance (always a percentage of the total bill) *or* copays, but not both.

Recommendation: HRD should continue to pursue best practices that have been shown to control health benefit costs.

Executive Position: I concur with the recommendation.

Schedule for Implementation and Comments: As I noted in my Budget speech and the Op/Ed that appeared in the November 14, 2003 *Seattle Times,* I have begun working on a comprehensive approach for controlling health benefits costs. My action plan goes beyond what we can do within King County's own plans to engage our employees as responsible and informed consumers, select "best in class" vendors for our programs, and implement a disease management program reinforced through financial incentives in the plan. In order for our employees to be more effective purchasers of health care, however, we need to find ways to address the estimated 25 – 30 percent of "waste" in health care reported in studies by groups such as the Dartmouth Center for Evaluative Clinical Science and the Institute of Medicine. To effectively reduce this waste, I believe that we must:

- Develop an independent source of **evidence-based** information for physicians and consumers about the effectiveness specific health care procedures;

- Explore ways to **measure the variation in clinical decision making**;
- Help **consumers size up** their understanding of the care they receive and the choices they are making.

Therefore my action plan has both an internal and external focus.

As a first step, I have included resources in the 2004 budget to support a major Labor-Management Collaboration project designed to determine and implement plan designs and specific consumerism and disease management programs for King County. These programs will be the subject of bargaining in 2004 for implementation in the 2006-2008 benefits package.

Second, I have called together a panel of employers, representatives of union health care trusts, and health care experts to recommend an innovative and achievable set of strategies to improve the quality of health care while moderating costs in the Puget Sound market. The task force will investigate and make recommendations on options to accomplish the mission, including, but not limited to:

1. **Phase One (mid-February)** Conduct a reality check for King County: Has King County accurately defined the problem and identified the most realistic, actionable elements to achieve quality of care and cost containment in its own plan? Our proposed elements are:

   Engage employees:
   - Educate our employees and their families about the realities of health care cost trends – help them understand that *we must be willing to explore whole new ways of evaluating and purchasing health care and helping employees be healthier so they don't need as many health care services* otherwise the only options available to the County will be:
     - significant cost share (premium and out-of-pocket) with employees;
     - significant reductions in force in all departments and all funds; and
     - significant reductions in benefits coverage.

   - Authorize immediate action and resources to implement a comprehensive education plan on the health care crisis, its potential effect on employees, and opportunities for improved health and higher-quality health care through active health care consumerism. This program is essential to successful labor-management collaboration on benefits.
   - Engage our employees as informed health care consumers by providing education and tools they can use to shop for high-quality health care services and improve their personal health status.

   Develop disease management and wellness programs:
   - Use actual claims data to identify most prevalent and costly health conditions; develop wellness and disease management programs for those conditions aimed at improving employee health and well-being, improving outcomes of care, and restraining increases in plan expenses.

Explore plan-design elements:

- Research cost sharing arrangements used by other comparable public employers and use that information to develop plan designs that share expenses as a percentage of total cost and that provide tools to employees for managing those expenses.
- Consider options for tailoring wages and benefits to meet employee needs for predictability of income and expenses through integrated bargaining of benefit and wage packages.

Influence the health care market:

- Improve employee health and the quality of health care available in the local market by purchasing *effective, evidence-based* care.
- Partner with other employers (public and private) to develop health care consumer education programs and decision tools, agree on a uniform set health care quality measurements, and encourage providers to participate in plans that reward high quality care.

2. Phase Two (June report): In order to accomplish the last two bullets concerning measuring performance in the Puget Sound health care market, make recommendations for:

a. Creating a process to be used in the Puget Sound region for developing consensus-based standards of health care cost and quality measurements designed to provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient.

b. Identifying an agency that will generate and make publicly available quality and economic efficiency performance information for all levels of care: health plans, hospitals, medical groups and individual physicians.

c. Encouraging providers to participate in plans the reward high quality, cost effective care.

d. Promoting consumer understanding and use of health care performance measures and other quality information.

e. Reinforcing and rewarding provider and patient focus on wellness, disease management, and active participation in health care decisions.

No one strategy will bring King County's health care costs under control; to be successful, the County must actively pursue both short term savings and long term reform of the health care market system.

cc: Sheryl Whitney, Assistant County Executive
Paul Tanaka, County Administrative Officer, Department of Executive Services (DES)
Anita Whitfield, Division Director, Human Resources Division (HRD), DES
Dave Lawson, Internal Auditor Supervisor, Executive Audit Services
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